Child's Emergency Information

Kid Central ___ Day Camp ___ Location_____

Family Information and Emergency Numbers

Child's Name (last name first): _____ Known As: _____
Sex: ____ Age: ____ Date of Birth: _____ Home Phone: _____
Home Address: _____ Zip: _____
School Child Attends: _____ Track: __A __B __C __D __Traditional
Mother's Name: _____ Home Phone: _____
Employer: _____ Business Phone: _____
Pager/Cellular #'s *(if applicable)*:_____
Father's Name: _____ Home Phone: _____
Employer: _____ Business Phone: _____
Pager/Cellular #'s *(if applicable)*:_____

Names of all persons, including parents/guardians, authorized to take the child from the facility.

Name Relationship Phone

_____
_____
_____

Additional persons who may be called in emergency to pick up child.

Name Relationship Phone

_____
_____
_____

Physician/Dentist to be called, if needed, in Emergency *(will call 911 when necessary)*

Physician Name: _____Phone: _____
Dentist Name:_____Phone_____
Local Hospital Preferred for Emergency Treatment :_____
Child's Medical Insurance: _____ **Medical Insurance Number**: _____
Allergies, limitations or dietary restrictions:_____
_____

Permission for Medical Treatment. The undersigned parent of _____ does hearby authorize Elk Grove Community Services District as its agent for the purpose of consenting to the examination, administering of anesthetic, medical or surgical diagnosis, treatment and hospital supervision by any physician or surgeon licensed by the State of California pursuant to the provisions of the Medical Practice Act, whether diagnosis or treatment is rendered at the office of said physician, the hospital or in the field.

It is understood this authorization is given in advance of any specified diagnosis, treatment or hospital care being rendered but is given to provide authority and power on the part of said agent to give specific consent to any and all such diagnosis, treatment, or hospital care which the afore-mentioned physician or surgeon in the exercise of their best judgement may deem advisable. This authorization is given pursuant to Section 25.8 of the Civil Code of California.

The undersigned in consideration for agent accepting such responsibility shall pay upon demand all medical cost incurred as a result of agents authorization whether or not such cost are covered by medical insurance.

This authorization should remain effective until _____, 20___ unless sooner revoked by written instrument delivered to agent prior to the exercise of the power and authority granted herein.

_____ _____
Signature of Parent / Guardian Date

For Office Use Only

Date forms received at office _____
Reviewed by Rec. Supervisor _____